

# **EXHIBIT 2**

Aetna Medicare

SilverScript Plus (PDP)

**Plan type:** Drug plan (Part D)

**Plan ID:** S5601-013-0

[Plan website](#) | **Non-members:** [1-833-526-2445](tel:1-833-526-2445) | **Members:** [1-866-235-5660](tel:1-866-235-5660)

What you'll pay

Total monthly premium	Retail pharmacy: 2022 estimated total drug costs
<b>\$73.30</b>	<b>\$2,720.80</b>
	Covers <b>1 of 2</b> drugs

Overview

PREMIUMS

Total monthly premium	\$73.30
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DEDUCTIBLES

The amount you must pay each year before your plan starts to pay for covered services or drugs.

Drug deductible	\$0.00
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CONTACT INFORMATION

<b>Plan address</b>	P.O. Box 30016 Pittsburgh, PA 15222
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# Drug Coverage

[See if there's help to lower costs for drugs you take.](#)

## PHARMACIES

See the cost level to fill your drugs at the pharmacies you chose. You can also change pharmacies to see the cost level of other pharmacies in your area to find the lowest cost pharmacy.

**CVS PHARMACY #10526**

Preferred

Preferred in-network pharmacy

## YEARLY DRUG COSTS BY PHARMACY

Drug costs shown vary based on the plan and pharmacy that you use. Contact the plan if you have specific questions about drug costs. [Can my drug costs change by pharmacy?](#)

**CVS Pharmacy #10526**

Preferred

Preferred in-network pharmacy

**Exelon 9.5mg/24hr patch 24 hour**

\$235.00


**Rivastigmine 9.5mg/24hr patch  
24 hour**

\$2,485.80

**Total yearly drug cost**

\$2,720.80

## ESTIMATED TOTAL DRUG + PREMIUM COST

	<b>CVS Pharmacy #10526</b> <span>Preferred</span> Preferred in-network pharmacy
<b>Total yearly drug + premium cost</b>	\$3,087.30
<b><u>When you'll enter the coverage gap</u></b> 	You won't enter the coverage gap in 2022

## ESTIMATED TOTAL MONTHLY DRUG COST

	<b>CVS Pharmacy #10526</b> <span>Preferred</span> Preferred in-network pharmacy
<b>August</b>	\$544.16
<b>September</b>	\$544.16
<b>October</b>	\$544.16
<b>November</b>	\$544.16
<b>December</b>	\$544.16

## ESTIMATED DRUG COSTS DURING COVERAGE PHASES

The drug prices shown may vary based on the plan and pharmacy you've selected. Contact the plan if you have specific questions about drug costs.

[Learn more about coverage phases.](#)

**CVS PHARMACY #10526**

	<b>Retail cost</b>	<b>Cost after deductible</b>	<b>Cost in coverage gap</b>	<b>Cost after coverage gap</b>
<b>Exelon 9.5mg/24hr patch 24 hour</b>	\$741.28	\$47.00	\$185.32	\$37.06
<b>Rivastigmine 9.5mg/24hr patch 24 hour</b> <sup>[1]</sup>	\$497.16	\$497.16	\$497.16	\$497.16
<b>Monthly totals</b>	\$1,238.44	\$544.16	\$682.48	\$534.22

[1]

This plan does not cover this drug, the price shown is the full cash price.

**COSTS BY DRUG TIER**

Plans group their drug lists into tiers. The drug costs below show how much you'll pay for drugs in each tier based on the coverage phase you're in.

[Learn more about drug tiers.](#)

	<b>Initial coverage phase</b>	<b>Gap coverage phase</b> <sup>[1]</sup>	<b>Catastrophic coverage phase</b>
<b>Preferred Generic</b>	\$0.00 copay	\$0.00 copay	<p>Generic drugs: \$3.95 copay or 5% (whichever costs more)</p> <p>Brand-name drugs: \$9.85 copay or 5% (whichever costs more)</p>
<b>Generic</b>	\$2.00 copay	\$2.00 copay	<p>Generic drugs: \$3.95 copay or 5% (whichever costs more)</p> <p>Brand-name drugs: \$9.85 copay or 5% (whichever costs more)</p>
<b>Preferred Brand</b>	\$47.00 copay	—	<p>Generic drugs: \$3.95 copay or 5% (whichever costs more)</p> <p>Brand-name drugs: \$9.85 copay or 5% (whichever costs more)</p>
<b>Non-Preferred Drug</b>	50%	—	<p>Generic drugs: \$3.95 copay or 5% (whichever costs more)</p> <p>Brand-name drugs: \$9.85 copay or 5% (whichever costs more)</p>

<sup>[1]</sup> For all other drugs, you pay 25% for generic drugs and 25% for brand-name drugs.

	<b>Initial coverage phase</b>	<b>Gap coverage phase</b> <sup>[1]</sup>	<b>Catastrophic coverage phase</b>
<b>Specialty Tier</b>	33%	—	<p>Generic drugs: \$3.95 copay or 5% (whichever costs more)</p> <p>Brand-name drugs: \$9.85 copay or 5% (whichever costs more)</p>

<sup>[1]</sup> For all other drugs, you pay 25% for generic drugs and 25% for brand-name drugs.

## OTHER DRUG INFORMATION

	<b>Tier</b>	<b>Prior authorization</b>	<b>Quantity limits</b>	<b>Step therapy</b>
<b>Exelon 9.5mg/24hr patch 24 hour</b>	Tier 3	—	<u>Yes</u>	—
<b>Rivastigmine 9.5mg/24hr patch 24 hour</b>	Not covered	—	—	—

	Package	Quantity	Frequency	Brand/Generic
Exelon 9.5mg/24hr patch 24 hour	Box of 30 patch 24 hours	1	Every month	Brand
Rivastigmine 9.5mg/24hr patch 24 hour	Box of 30 patch 24 hours	1	Every month	Generic

PART B DRUGS

These are drugs you usually get at a doctor's office or hospital outpatient setting, like the flu shot, chemotherapy, or other shots.

Chemotherapy drugs	Not covered	
Other Part B drugs	Not covered	

Star ratings

+ Expand All Ratings

Overall star rating	★★★★☆
Overall rating is based on the categories below.	
+ Drug plan star rating	
Summary rating of drug plan quality	★★★★☆